# Correctional Health Care: Potential Impacts of National Health Care Reform

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Over the past several months there has been an enormous amount of discussion and speculation about health care reform. Questions most often asked are: What is the most effective approach? How will it affect our society? And, How will it be financed?

As these issues are pondered, the correctional health care industry is interested in the impact of projected reforms on the health care services provided in the nation's jails and prisons. In my opinion, health care reform under the Clinton plan, regardless of its final format, will have minimal impact on corrections because the key components of the plan have been fundamental correctional health care principles for the past ten to fifteen years.

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To substantiate this hypothesis, I will attempt in this article to:

- Identify key problems addressed by health care reform:
- Identify the reforms most frequently proposed;
- Identify the consensus features of health care reform;
- Highlight the key elements of the Clinton plan; and
- Evaluate how the proposed reforms will affect correctional health care delivery systems.

## What Problems Will Health Care Reform Address?

Cost! Accelerating health care cost is the driving force behind reform. For the past fifty years, public health officials, health providers, and economists have attempted to find effective ways of controlling the cost of health care in the United States. In spite of a variety of strategies, however, costs continue to increase. At the same time, a large number of Americans have either inadequate health insurance or none at all and, as a result, may receive inadequate care or risk financial ruin.

It is also clear that the current system is not equipped to handle the changing demographics of our society or the spread of HIV disease, tuberculosis, and other communicable diseases. Limited access, high costs, confusing regulations, mounds of paperwork, and administrative nightmares describe our current system and the problems health care reform seeks to address.

Purely from a public health perspective, the only way to control health care costs is to change the way we spend the American health care dollar. Ninety-seven cents of each health care dollar are spent on acute and chronic medical care, while only three cents are spent on preventive health care. Only when we change our behaviors (in terms of diet, smoking, and exercise) will we see a decrease in the annual rate of growth in health care expenditures. Our behavior is not likely to change over night, and politicians are not willing to invest in programs that will not pay off for fifteen to twenty years.

## Commonly Proposed Reforms

Given this environment and its complex problems, the following types of reform have been those most frequently considered:

- **Voucher systems, in** which vouchers would be distributed to insurance companies to cover the poor and to provide tax deductions for the middle class. This Bush Administration proposal would have provided minimal cost controls except for malpractice reforms and networks using volume purchases to obtain benefits for small groups at lower cost.

- **Managed competition, in** which the government regulates the market to increase competition based on price and quality and informs consumers to increase their bargaining power and motivate them to shop for the best value available.

- **Managed care,** a related concept, is described as various degrees of organized and directed services provided through health maintenance organizations, independent practice associations, preferred provider organizations, and the monitoring of employee utilization.

Several components are common to each of these reform proposals:

- Universal access;
- Cost controls;
- The patient's freedom to choose a physician;
- The scope of benefits; and
- Co-payments.

When one considers why health care reforms are needed, these common elements are quite logical.

## What are the Nuts and Bolts of the Clinton Plan?

As of September 22, 1993, the Clinton plan relied primarily on the managed care approach and had the following components:

- **Who** is **covered:** All U.S. citizens, including those abroad, and legal residents. Prisoners and illegal immigrants would not be covered unless a state decides otherwise. Programs for Native Americans and veterans would be separate.

- **Who pays:** Business would pay 80 percent of premiums, employees, 20 percent. Part-lime workers would be covered on a prorated basis.

- **Cost:** Annual premiums would be approximately $1,800 for an individual and $4,200 for a family.

- **Choice of physician: In** a low-cost health maintenance organization, participants are assigned a doctor. In the highest-cost program, participants choose a doctor and pay more. A third option provides a network of doctors and services to choose from.

- **What is covered: The scope** of benefits includes hospital treatment, office visits, prescription drugs, dental work for children, mental health and substance abuse treatment, pregnancy services, and rehabilitation services. Not covered are cosmetic surgery, private nursing services, private hospital rooms, experimental treatments, hearing aids, adults' dental work before the year 2000, in-vitro fertilization, sex change surgery, or breast reconstruction.

## How Will the Proposed Reforms Affect Correctional Health Care Delivery?

Although the Clinton health plan has other elements, the important components for evaluating its impact on correctional health care have been identified. We may thus proceed with testing the hypothesis that health care reform will have little impact on how we deliver correctional health care.

**Universal access.** The basis for my hypothesis is related to the key component of "universal access? It has always been my philosophy that the inmate's constitutional right to health care is the most significant example of health care as a right versus a commodity and that it is the free-world practice of medicine that needs to be changed. In a sense, the incarcerated have had "universal access" to health care for the past ten to fifteen years, including the right to any treatments recommended by health professionals.

It is noteworthy that the Clinton plan places the burden of treating the incarcerated on the states. This is essentially a moot issue in terms of state prisoners, while the burden for financing health care for city and county jail inmates rests with the local jurisdiction. The end result is that access to care will not change for the incarcerated inmate.

**Co-payments and premiums.** The issue of who pays for inmate health care is fairly clear-it is and will continue to be the state or the local jurisdiction. However, the potential for inmate co-payment becomes a legitimate issue in that this would be consistent with thecommunity standard. Moreover, recent litigation on this issue, particularly in the state of Nevada, has upheld a correctional agency's right to require inmate co-payments. As a word of caution, it is important that an agency have well-defined criteria and objectives for inmate co-payment and does not count on receiving revenues adequate to offset the cost of inmate health care.

There have been no definitive studies of correctional health delivery systems that provide hard data on the annual, per-inmate cost of medical care. However, surveys report a high of $2,600 per inmate-year and a low of $750. The general estimate of industry providers is that the average cost nationwide is between $1,500 and $1,800 per inmate-year. Interestingly, this figure correlates very closely with the estimated average health care premium for individual per year under the Clinton plan, which is proposed at $1,800.

**Choice of physician.** One of the most often-heard arguments against health care reform is that it will provide limited choice of physician-or even no choice-unless the individual co-pays for that option. In general, the incarcerated individual is assigned to a correctional facility's physician/mid-level practitioner, and this is likely to continue to be the case. However, there are appropriate situations in which an inmate has a right to a second opinion from either another facility physician or an outside consultant.

**Scope of benefits.** One area in which significant change in correctional health care may be expected is in the scope of benefits. Changes here may help correctional health care providers make services more appropriate and cost-efficient. Inmates often demand specific types of medical services and even bring suit based on community standards in terms of special services including cosmetic surgery, sex change surgery, and orthodontic dental work. The Clinton plan, which sets guidelines and parameters for a well-defined scope of benefits, could provide the basis for setting similar parameters in corrections. In other words, if inappropriate and unnecessary services and procedures are not covered under the free world plan, there would be no legal basis for requiring them to be covered in the correctional health care system.

**By defining a community standard of care that does not include such treatments as cosmetic surgery and sex-change operations, the Clinton plan could reduce the legal basis of inmate claims that corrections should provide these services.**

## Correctional Health Care as a Laboratory for Cost Control

The final area of health care reform I would like to discuss has to do with cost control strategies. Examples being demonstrated in correctional systems include group purchasing, competitive contracting, and others.

**Group purchasing.** Many correctional health care providers have instituted cost control measures over the past several years in response to decreased funding. Some jails and prisons have instituted formal buyer groups for purchasing pharmaceuticals, and others have joined with local county health departments or are purchasing through national pharmaceutical vendors.

**Competitive contracting.** In the U.S., there are currently no fewer than ten providers of correctional health care who bid on contracts for health care services. Increasing competition among contract

providers can result in significant cost containment. Although I do not advocate contracting for health care services in every institutional setting, there are merits to contracting for specialized services such as radiology, orthopedics, and laboratory services. Contracting basic medical services in jails and prisons with fewer than 2,000 inmates also has a good potential for being cost-efficient.

Other innovative strategies. Additional options for reducing health care costs include providing over-the-counter medication through the inmate commissary (see article, p. 14); instituting inmate self-medication programs; using generic as opposed to brand-name drugs; contracting for mobile dialysis services provided at the facility; and developing automated medical information systems.

This review is over-simplified. Nevertheless, the evidence does seem to support the hypothesis that correctional health care, itself a model of managed care, already reflects the core elements that have been proposed for a reformed system of health care in the U.S. The correctional health care system, like the system being proposed, has the following attributes:

- It provides universal access;
- The scope of benefits is defined;
- It can utilize combined buying power and competitive bidding to reduce costs; and
- It encourages the use of innovative cost controls.

I therefore believe the effect of health care reform on the correctional health care delivery system will be minimal, yet positive-minimal because managed care is, at least to some extent, currently being practiced; positive because the scope of benefits defined in the Clinton plan will become the community standard. This will, in turn, give the correctional health care provider a solid legal basis for narrowing the scope of care without worrying about a potential suit for not providing cosmetic or other unnecessary services.

Another positive benefit may be that correctional health care providers can continue to be innovative in developing new cost control measures such as:

- Tele-Med case conferences, enabling physicians to discuss options for case management through a televised link-up;
- Automated medical record systems that are shared by local jails and state prisons;
- Multi-jurisdictional acute-care hospitals serving local jails and state and federal prisons; and
- Co-ed medical services in correctional treatment centers and jail infirmaries.

Correctional health care can be viewed on the one hand as "the last frontier of organized medicine," and on the other as at the cutting edge of innovation and health care reform. It is essential that, as health care providers in the correctional setting, we participate in structuring health care reform and monitor its progress so that our services meet the standard of care in the community.

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